Community Healthlink

Describing the process of assessing, planning, providing and monitoring comprehensive integrated services through a case illustration.

Why did we choose this example?

1. Good example of an individual with major psychiatric, substance abuse, and physical health issues.
2. Major family issues, a father, trauma history
3. Importance of staying connected as a team and helping the individual feel that he is part of a team that will help him
4. Welcoming and affirming when he is lost for awhile, relapses, legal trouble.
5. Language, culture and cognitive/ learning issues to consider
6. This type of team is meant to take care of folks like him.

Community Healthlink
Worcester, MA Cohort 3

Community Mental Health Center

Outpatient mental health and substance abuse treatment

Residential substance abuse treatment

Housing and Community Support

We provide our own primary care with support of the UMass Department of Family and Community Medicine

Personal History

- 43 yo man, originally from Puerto Rico, primarily Spanish Speaking, difficulty with literacy in Spanish. Some grade school.
- Limited information regarding childhood history. In prison 10-15 years. History of trauma there and started to use opiates.
- Currently separated in context of relationship discord form partner of over 12 years, homeless, living in Respite, father of a 22 yo living in Western Mass, 10 yo biological child and 2 younger step children locally.

Psychiatric and Substance Abuse History

- Schizoaffective disorder with recurrent depression, voices that are negative and critical. Depression with thoughts of suicide. Referred to CMHC from FQHC due to severity of psychiatric illness.
- Tremendous anxiety, feels safest staying in his room, isolated, fearful when he goes out in the community
- Opiate dependence, success on suboxone in past
- Tobacco dependence, one pack per day

Physical Health History

- Hepatitis C
- Gastroesophageal Reflux
- Diabetes Type II
- Hypertension
- Limited connection to pcp at FQHC, need for suboxone

Initial Health Indicators July 2011

- Height: 5ft 8 in
- Weight: 187 lbs
- BMI: 28.4
- Waist: 39
- BP (systolic): 114 BP (diastolic): 84 Pulse:90
- HgA1C: 5.5
- Lipid Profile: HDL: 33 Flag LDL: 69 Triglycerides 164 Flag : Total Cholesterol: 135
- Carbon Monoxide: 11/11 : 74

Current medications

Seroquel 50 mg tablet, 1 Tablet(s), PO, QD PRN
Seroquel 100 mg tablet, 1 Tablet(s), PO, QHS
Colace 100 mg capsule, 1 Capsule(s), PO, BID PRN
Suboxone 8 mg-2 mg sublingual tablet, 1 Tablet(s), SL, BID

albuterol sulfate HFA 90 mcg/actuation Aerosol Inhaler, 2 Puff(s), INH, QID PRN
metformin 500 mg tablet, 1 Tablet(s), PO, BID
lisinopril 20 mg tablet, 1 Tablet(s), PO, QD
aspirin 81 mg tablet,delayed release, 1 Tablet(s), PO, QD
senna 8.6 mg tablet, 2 Tablet(s), PO, BID
Protonix 40 mg tablet,delayed release, 1 Tablet(s), PO, QD

Initial engagement in the PBHCI service model

- Referred by therapist and psychiatrist, both Spanish speaking via administrative coordinator for primary care who is also a native Spanish Speaker
- Saw primary care first because he was in need 6/23/11, then enrolled in Wellness services and formally agreed to enter the program 7/11.
- Referred for in house suboxone treatment via psychiatry

Assessment Process: Client H indicators plus additional health conditions

Nurse Care Manager gathered initial data from interview with interpretation, psychiatric emr, primary care emr.

1. PBHCI Physical Health Registry- Physical Health Assessment
2. PBHCI Nursing Note- wellness assessment and goals
3. Assesses mechanical indicators herself.
4. Labs ordered via the nurse per primary care order(could be psychiatric practitioner also)
5. Collaborates with therapist, psychiatrist, and pcp

Assessment Process: NOMS

Research assistant- evaluation team:

Baseline 7/11 and follow up since that time.

Tracks those that need follow up mechanical measures and labs.

Data from patient interview, psychiatric EMR and Primary Care EMR. In this case with interpretation.

Team Meeting

Weekly, all members of the PBHCI team

Solicit input in advance from the individual, other providers

Given: Spanish language, opiate depedence, need for rx for addiction and Hep C, unstable family situation, severity of psychiatric symptoms- best served in wrap around services of our team.

Planning: Individualized Integrated Care Plan

A. Primary care services: NP, MA, Adm

- Need good initial assessement and GI referral for Hep C
- 12 visits and 3 no shows over since 6/11- including successful GI consult after no shows
- Successful cardiac consultation
- Work on hypertension, smoking, diabetes

Planning: Individualized Care Plan

B. Behavioral health service

- Therapy weekly- monthly, some family, some outreach when missing. 30 visits since 3/11. Many no shows
- Providers: LICSW Spanish speaking, trauma expertise, Psychiatrist dual disorders focus- 28 visits since 3/11
- Focus of treatment: Family work, harm reduction, symptom reduction, better function. What is really going on??

Planning: Individualized Care Plan

C. Wellness Activities/services

- Attempt to meet at least monthly
- Nurse Care Manager- 13 visits since 7/11
- Nutrition and physical activity related to diabetes management and hypertension. Discussion of smoking cessation. Did accept patch at one visit

Progress Monitoring (H indicators and other health conditions)

- How are H indicators/other conditions monitored?
- Reviewed and ordered at pcp and psychiatry visits. Nurse care manager alerts primary care or psychiatric provider when due, at least annually
- Emergency room visit 10/12 erosive esophagitis

How is information accessed?

How is information shared with client and the integrated care team?

- Prior to primary care visits: LPN gathers labs, meds, er visits, 3 EMRs plus calling another. Discussed with client in the visit with plans
- Nurse care manager in context of wellness activities will review with client based on pcp and psychiatric visits
- Psychiatric visits- rely on getting information directly from patient and primary care.
- Periodic review in the team meetings.
- Morning huddles

Current H Indicators 10/12

Cholesterol 144

Trig 105

HDL 41

LDL 82 VLDL 21

HGB A1C 5.3 average glucose 105

Blood pressure 122/75

Wt 195 lbs, BMI 29.6

CO

Other Outcomes so far

Homeless, but out of a difficult relationship, hopeful about getting his own place.

Much more open and talkative with all of us

Despite at least two relapses back on suboxone

Contemplative with regard to smoking cessation

Cardiac disease ruled out with consultation accomplished

Liver consultation accomplished to consider further Hep C treatment.

He is not giving up and neither are we!

Future Directions

1. Relationship, relationship, relationship- it can be anyone on the team, preferably several that the person is most comfortable.
2. Integrated health record- need to have easy access to health indicators at the opening of a chart without hunting
3. Moving forward with funding opportunities in Massachusetts for those on medicaid and medicare. We want to be the provider of choice for those most in need!